



State of Louisiana

Department of Health and Hospitals
Office of Aging and Adult Services
Traumatic Head & Spinal Cord Injury Trust Fund

Thank you for requesting information from the Traumatic Head and Spinal Cord Injury Trust Fund.

The Application for Services packet includes the application and the Medical Eligibility forms. Please make sure when you return this application the Medical Eligibility form is included. The **Medical Eligibility Form** MUST be completed and signed by a MEDICAL DOCTOR before sending the application back to us.

PLEASE DO NOT FAX THIS APPLICATION BACK TO US

Return the completed forms to:

THI/SCI Trust Fund Program
P.O. Box 2031 – BIN #14
Baton Rouge, LA 70821-2031

If you have any questions, or need any additional information, please feel free to contact our office at: 1-888-891-9441 or (225) 219-2410.

For additional resources, please contact:

The Traumatic Head and Spinal Cord Injury Resource Center
8325 Oak Street,
New Orleans, La 70118
1-504-982-0685
Info@biala.org

Sincerely,

A handwritten signature in cursive script that reads "Alicia Smith".

Alicia Smith
Program Manager

**The Traumatic Head
and Spinal Cord Injury**

Trust Fund

must always be

the last source used to

pay for services.

**Traumatic Head and
Spinal Cord Injury
Trust Fund Program**

P.O. Box 2031 Bin 14
Baton Rouge, LA 70821-2031

Email: THSCI@la.gov

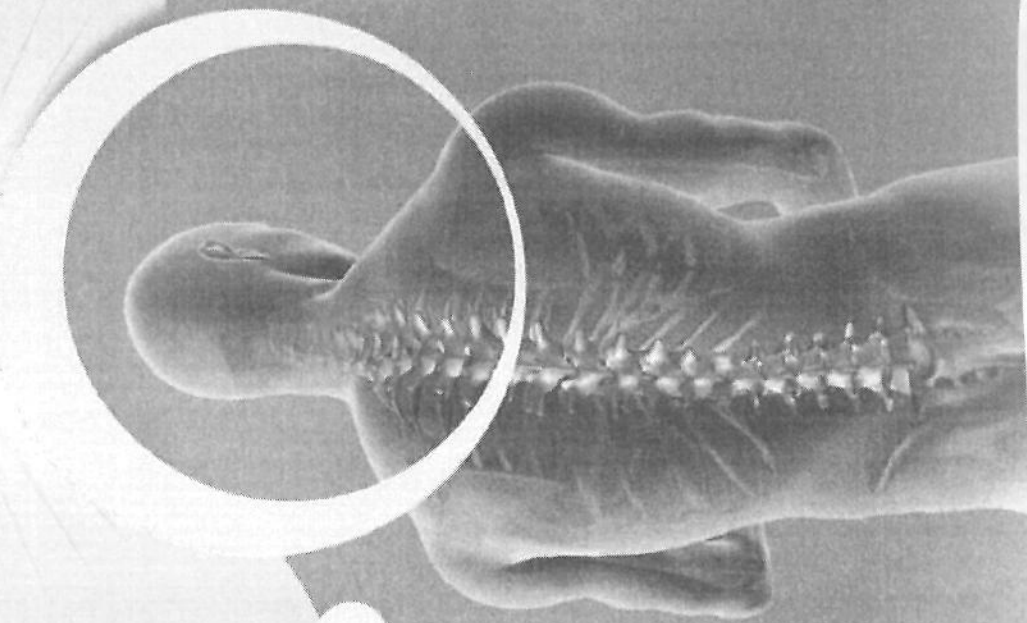
1-888-891-9441



**DEPARTMENT OF HEALTH
AND HOSPITALS**

Aging and Adult Services

**Traumatic Head
and Spinal Cord
Injury Trust Fund**



To apply for services:

**Traumatic Head and
Spinal Cord Injury
Trust Fund Program**

P.O. Box 2031 Bin 14
Baton Rouge, LA 70821-2031

1-888-891-9441

Email: THSCI@la.gov

This public document was published for a total cost of \$888.93. 10,000 copies of this public document were published in this first printing. This document was produced by the Department of Health and Hospitals Office of Aging and Adult Services. It was printed in accordance with standards for printing by State Agencies established pursuant to R.S. 43:31. This publication was supported by the Traumatic Head and Spinal Cord Injury Trust Fund, 628 North 4th Street, Baton Rouge, LA 70802.

What is the Trust Fund Program?

The Trust Fund Program was created by Act 654 of the 1993 Regular Session of the Louisiana Legislature.

The Trust Fund Program receives funding from additional fees which are imposed on motor vehicle violations in Louisiana for offenses of driving under the influence, reckless operation and speeding.

The program provides services in a flexible, individualized manner to Louisiana citizens who survive traumatic head or spinal cord injuries to enable them to return to a reasonable level of functioning and independent living in their communities.

What is a Traumatic Head Injury?

An insult to the head, affecting the brain, not of a degenerative or congenital nature, but caused by an external physical force that may produce diminished or altered state of consciousness which results in an impairment of cognitive abilities or physical functioning. The impairment may be either temporary or permanent and cause partial or total functional disability psychological maladjustment.

What is a Spinal Cord Injury?

An insult to the spinal cord, not of a degenerative or congenital nature, but caused by an external physical force resulting in paraparesis/paraplegia or quadriplegia/quadruplegia.

What is the eligibility criteria for the Trust Fund Program?

- ▶ Meet the definition of traumatic head injury or spinal cord injury as defined in this brochure.
- ▶ Be "medically stable" by having normal vital signs, no progression of deficits and/or no deterioration of physical or cognitive status; and by not requiring acute daily medical intervention.
- ▶ Have reasonable expectation to achieve a predictable level of outcome to achieve improvement in quality of life and/or functional outcome.
- ▶ Be willing to accept treatment from a Trust Fund approved facility or program.
- ▶ Be a resident of Louisiana, a U.S. citizen, and officially domiciled in Louisiana at the time of injury and during the provision of services.
- ▶ Have exhausted all other governmental and private sources of funding for services.
- ▶ Provide proof of denial from other sources of funding for services.
- ▶ Must complete and submit an appropriate application for services from the Trust Fund Program.

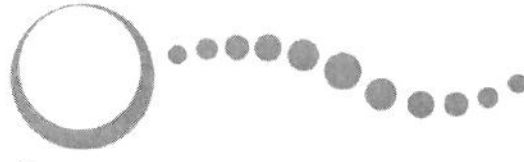
What limitations apply to this program?

- ▶ The Trust Fund will not provide any service that is experimental.
- ▶ The service providers must be approved by the Traumatic Head & Spinal Cord Injury Trust Fund Program. In-state facilities/programs are given priority for approval as service providers.
- ▶ Services are provided on a first-come, first-served basis.
- ▶ Expenditures shall not exceed \$15,000 for any 12-month period with a \$50,000 lifetime maximum per person.

What is provided by the Trust Fund Program?

- ▶ Evaluations
- ▶ Post-acute medical care rehabilitation
- ▶ Therapies
- ▶ Medication
- ▶ Attendant care
- ▶ Equipment necessary for activities of daily living

For more information about the Traumatic Head and Spinal Cord Injury Trust Fund program or to apply for services, please call 1-888-891-9441. The call is toll free.



APPLICATION FOR SERVICES

TRAUMATIC HEAD AND SPINAL CORD INJURY TRUST FUND PROGRAM

P.O. Box 2031-BIN #14, BATON ROUGE, LA 70821-2031 • PHONE 1-888-891-9441 OR (225) 219-2410

Name: (Last, First, MI) _____		Social Security Number: _____ / /		Telephone Number: _____ () -	
Home Address: _____					
City: _____		State: <u>LA</u>		Zip Code: _____	
Mailing Address (If different from home address) _____					
City: _____		State: <u>LA</u>		Zip Code: _____	
<small>Please Note if your address or phone number changes before we contact you and you fail to notify us every reasonable attempt will be made to contact you. If we cannot contact you, your name will be skipped and the next person on the waiting list will be contacted. I understand this statement.</small>					
Signature _____					
Parish: _____		Contact Person: _____		Telephone: () -	
<small>Someone who will know how to contact you in the event you do move.</small>					
Date of Birth: _____ / /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Highest Grade Completed	
How did you hear about the program?					
List services you are requesting: <input type="checkbox"/> Attendant Care <input type="checkbox"/> Post Acute Medical Care <input type="checkbox"/> Evaluations <input type="checkbox"/> Therapies <input type="checkbox"/> Equipment Necessary for Daily Living <input type="checkbox"/> Other					
IF OTHER – PLEASE BE MORE SPECIFIC ABOUT SERVICES YOU ARE REQUESTING:					
Primary Diagnosis: <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Spinal Cord Injury					
Primary Treating Physician's Name: _____			Other Physician's Name: _____		
Mailing Address: _____			Mailing Address: _____		
City: _____ State: _____ Zip: _____			City: _____ State: _____ Zip: _____		
How were you injured?				Date of Injury: _____ / /	
Where were you living AT TIME of the injury? City: _____ State: _____					
Is this where the ACCIDENT TOOK PLACE ? () YES () NO					
If NO – City: _____ State: _____					
Were you employed at the time of your injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name and address of employer:					
Are you presently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, give name and address of employer:					
Please check off all services you are currently receiving:					
<input type="checkbox"/> SSI	<input type="checkbox"/> Medicaid	<input type="checkbox"/> NOW Waiver			
<input type="checkbox"/> SSDI	<input type="checkbox"/> Medicare	<input type="checkbox"/> Supports Waiver			
<input type="checkbox"/> Veteran's Benefits	<input type="checkbox"/> Private Medical Insurance	<input type="checkbox"/> Long Term Personal Care			
<input type="checkbox"/> Vocational Rehabilitation Services	<input type="checkbox"/> EDA Waiver	<input type="checkbox"/> Community and Family Support			
<input type="checkbox"/> Private Disability Insurance Benefits	<input type="checkbox"/> ADHC Waiver	<input type="checkbox"/> State Personal Assistance Services			

PLEASE READ CAREFULLY – DO NOT SIGN UNLESS YOU UNDERSTAND. CALL IF YOU HAVE QUESTIONS. CHECK THE APPROPRIATE BOX IF YOU WANT A COPY

I hereby apply for services through the Louisiana Traumatic Head and Spinal Cord Injury (TH/SCI) Trust Fund. **I will voluntarily provide information relative to my disability/injury/accident and resources available to me.** Refusal to provide such information could affect my eligibility for services. I understand that such information will be held confidential and will be used only insofar as it affects my eligibility for the program and the delivery of services. Information will be released only with my authority and written consent or as otherwise authorized by the policy of the Louisiana Traumatic Head and Spinal Cord Injury Trust Fund.

I understand that eligibility decisions will be made without regard to sex, race, creed, color or national origin. I further understand that eligibility decisions will be made without regard to disability unless, and only to the extent necessary, authorized by law to comply with Act 654 of the 1993 Louisiana Legislature.

I have been advised that if I am dissatisfied with any Louisiana Traumatic Head and Spinal Cord Injury Trust Fund Program action regarding either eligibility or the provision of services, I may request an Administrative Review with the Program Manager of the Trust Fund Program. The Administrative Review process generally provides for a more timely resolution of disagreements. If the disagreement is not adequately resolved through the Administrative Review, I may request an Advisory Board Review. My request for either an Administrative Review or Advisory Board Review must be made in writing to the Program Manager of the Trust Fund Program, P.O. Box 2031-BIN #14, Baton Rouge, LA 70821-2031, within ten (10) days of learning of the decision with which issue taken.

I certify that the information I have given is true, correct and complete to the best of my knowledge and that knowingly providing false or incorrect information is cause for immediate termination of benefits. I agree to notify my Case Manager or the program office within 30 days if I have a change in my financial condition, my physical or mailing address(es). I understand that if I knowingly provide information which is incorrect, I may be required to reimburse, in whole or in part, the TH/SCI Trust Fund for funds provided to pay for the cost of certain services I have received.

DO NOT SIGN UNLESS YOU FULLY UNDERSTAND THE ABOVE THREE PARAGRAPHS

Signature of Applicant

Date of Application

Signature of Guardian (required if applicant is under 18 yrs of age)

THIS IS FOR YOUR USE AS A REMINDER. PLEASE CHECK OFF EACH FORM BELOW TO ASSURE THE FOLLOWING FORMS ARE ATTACHED TO THIS APPLICATION.

☐ MEDICAL ELIGIBILITY FORM

APPLICATIONS WITHOUT THE ABOVE DOCUMENTATION WILL NOT BE PROCESSED.

☐ Please mail me a copy of this form

Mailed _____
Date

MEDICAL ELIGIBILITY FORM

**** FORM MUST BE COMPLETED BY TREATING PHYSICIAN ****

****Please RETURN to the client – to be mailed back **WITH** the application****

REFERRED INDIVIDUAL: _____ SOCIAL SECURITY NO.: _____ - _____ - _____

I. MEDICAL STABILITY (Please check one of the following:)

____ Patient is medically stable. (Has normal vital signs, no progression of deficits and/or deterioration of physical/cognitive status. Does not require acute medical intervention.)

COMMENTS: _____

____ Patient is medically unstable. (Has fluctuating vital signs requiring acute medical attention. Progression of neurologic deficits and/or deterioration of medical condition.)

COMMENTS: _____

II. SPINAL CORD INJURY

A. Did the injury result from an insult to the spinal cord caused by external force? ____ YES ____ NO (If NO, go to Item III)

B. Cause of injury: _____

C. ____ Paraplegia ____ Quadriplegia

D. COMMENTS: _____

E. RECOMMENDATIONS:

____ Evaluation
____ Attendant Care
____ Post Acute Medical Care
____ Equipment necessary for Daily Living
____ Therapies
____ Other

EXPLANATIONS FOR OTHER: (Please be specific)

III. TRAUMATIC HEAD INJURY

A. Did the injury result from an insult to the head, affecting the brain, caused by an external force? ____ YES ____ NO

B. If YES to the above, which of the following were produced by the injury? ____ Altered state of consciousness

____ Motor deficit present ____ Sensory deficit present ____ Cognitive/behavioral deficit

C. ____ Other, please be specific: _____

D. Circle RANCHO Level: 1 2 3 4 5 6 7 8

E. DIAGNOSIS: _____

F. COMMENTS: _____

G. RECOMMENDATIONS:

____ Evaluation
____ Attendant Care
____ Post Acute Medical Care
____ Equipment necessary for Daily Living
____ Therapies
____ Other

EXPLANATIONS FOR OTHER: (Please be specific)

PHYSICIAN'S SIGNATURE

PHYSICIAN'S PRINTED NAME

DATE

PRINT PHYSICIAN'S ADDRESS

() -
PHYSICIAN'S PHONE NUMBER

NOTE: This form is invalid without signature and readable contact information from the completing physician.

ACADIA
568 NW Court Circle
Crowley, LA 70526-4363
(337) 788-8841

ALLEN
P. O. Box 150
Oberlin, LA 70655-0150
(337) 639-4966

ASCENSION
828 S. Irma Blvd. - #205
Gonzales, LA 70737-3631
(225) 621-5780

ASSUMPTION
P. O. Box 578
Napoleonville, LA 70390-0578
(985) 369-7347

AVOUELLES
312 N. Main St. - #E
Marksville, LA 71351-2409
(318) 253-7129

BEAUREGARD
P. O. Box 952
DeRidder, LA 70634-0952
(337) 463-7955

BIENVILLE
P. O. Box 697
Arcadia, LA 71001-0697
(318) 263-7407

BOSSIER
P. O. Box 635
Benton, LA 71006-0635
(318) 965-2301

CADDO
P. O. Box 1253
Shreveport, LA 71163-1253
(318) 226-6891

CALCASIEU
1000 Ryan St. - #7
Lake Charles, LA 70601-5250
(337) 437-3572

CALDWELL
P. O. Box 1107
Columbia, LA 71418-1107
(318) 649-7364

CAMERON
P. O. Box 1
Cameron, LA 70631-0001
(337) 775-5493

CATAHOULA
P. O. Box 215
Harrisonburg, LA 71340-0215
(318) 744-5745

CLAIBORNE
507 W. Main St. - Suite 1
Homer, LA 71040-3914
(318) 927-3332

CONCORDIA
4001 Carter St. - #4
Vidalia, LA 71373-3021
(318) 336-7770

DESOTO
105 Franklin St.
Mansfield, LA 71052-2046
(318) 872-1149

E. BATON ROUGE
222 St. Louis - #201
Baton Rouge, LA 70802-5860
(225) 389-3940

E. CARROLL
P. O. Box 708
Lake Providence, LA 71254-0708
(318) 559-2015

E. FELICIANA
P. O. Box 488
Clinton, LA 70722-0488
(225) 683-3105

EVANGELINE
200 Court St. - Ste. 102
Ville Platte, LA 70586-4463
(337) 363-5538

FRANKLIN
Courthouse
6560 Main St.
Winnsboro, LA 71295-2750
(318) 435-4489

GRANT
Courthouse
200 Main St.
Cottax, LA 71417-1828
(318) 627-9938

IBERIA
300 S. Iberia St. - #110
New Iberia, LA 70560-4543
(337) 369-4407

IBERVILLE
P. O. Box 554
Plaquemine, LA 70765-0554
(225) 687-5201

JACKSON
500 E. Court St. - #102
Jonesboro, LA 71251-3400
(318) 259-2486

JEFFERSON
P. O. Box 10494
Jefferson, LA 70181-0494
(504) 736-6191

JEFFERSON DAVIS
302 N. Cutting Ave.
Jennings, LA 70546-5361
(337) 824-0834

LAFAYETTE
1010 Lafayette St. - #313
Lafayette, LA 70501-6885
(337) 291-7140

LAFOURCHE
307 W. 4th St.
Thibodaux, LA 70301-3105
(985) 447-3256

LASALLE
P. O. Box 2439
Jena, LA 71342-2439
(318) 992-2254

LINCOLN
100 W. Texas Ave.
Ruston, LA 71270-4463
(318) 251-5110

LIVINGSTON
P. O. Box 968
Livingston, LA 70754-0968
(225) 686-3054

MADISON
100 N. Cedar St.
Tallulah, LA 71282-3892
(318) 574-2193

MOREHOUSE
129 N. Franklin St.
Bastrop, LA 71220-3815
(318) 281-1434

NATCHITOCHES
P. O. Box 677
Natchitoches, LA 71458-0677
(318) 357-2211

ORLEANS
1300 Perdido St. - #1W23
New Orleans, LA 70112-2127
(504) 658-8300

OUACHITA
122 St John St #114
Monroe, LA 71201-7342
(318) 327-1436

PLAQUEMINES
P. O. Box 989
Port Sulphur, LA 70083-0989
(504) 934-3620

POINTE COUPEE
211 E. Main St.
New Roads, LA 70760-3661
(225) 638-5537

RAPIDES
701 Murray St.
Alexandria, LA 71301-8099
(318) 473-6770

RED RIVER
P. O. Box 432
Coushatta, LA 71019-0432
(318) 932-5027

RICHLAND
P. O. Box 368
Rayville, LA 71269-0368
(318) 728-3582

SABINE
400 Capitol St. - #107
Many, LA 71449-3099
(318) 256-3697

ST. BERNARD
8201 W. Judge Perez - Rm. 104
Chalmette, LA 70043-1696
(504) 278-4231

ST. CHARLES
P. O. Box 315
Hahnville, LA 70057-0315
(985) 783-2731

ST. HELENA
P. O. Box 543
Greensburg, LA 70441-0543
(225) 222-4440

ST. JAMES
P. O. Box 179
Convent, LA 70723-0179
(225) 562-2330

ST. JOHN
1801 W. Airline Hwy
LaPlace, LA 70068-3344
(985) 652-9797

ST. LANDRY
P. O. Box 818
Opelousas, LA 70571-0818
(337) 948-0572

ST. MARTIN
415 Saint Martin St.
St. Martinville, LA 70582-4549
(337) 394-2204

ST. MARY
500 Main St. - #301
Franklin, LA 70538-6144
(337) 828-4100

ST. TAMMANY
701 N. Columbia St.
Covington, LA 70433-2709
(985) 809-5500

TANGIPAHOA
P. O. Box 895
Amite, LA 70422-0895
(985) 748-3215

TENSAS
P. O. Box 183
St. Joseph, LA 71366-0183
(318) 766-3931

TERREBONNE
P. O. Box 9189
Houma, LA 70361-9189
(985) 873-6533

UNION
P. O. Box 235
Farmerville, LA 71241-0235
(318) 368-8660

VERMILION
100 N. State St. - #120
Abbeville, LA 70510
(337) 898-4324

VERNON
P. O. Box 626
Leesville, LA 71496-0626
(225) 239-3690

WASHINGTON
Courthouse Bldg.
900 Washington St.
Franklinton, LA 70438
(985) 839-7850

WEBSTER
P. O. Box 674
Minden, LA 71058-0674
(318) 377-9272

W. BATON ROUGE
P. O. Box 31
Port Allen, LA 70767-0031
(225) 336-2421

W. CARROLL
P. O. Box 71
Oak Grove, LA 71263-0071
(318) 428-2381

W. FELICIANA
P. O. Box 2490
St. Francisville, LA 70775-2490
(225) 635-6161

WINN
119 W. Main St. - Room 105
Winnfield, LA 71483-3238
(318) 628-6133

OFFICIAL USE ONLY

Address Change

Name Change

Party Change

Remarks

Circle One: PA MV RG SDA SS(Disability)

Received by: _____

PLACE IN AN ENVELOPE AND MAIL TO YOUR
REGISTRAR OF VOTERS

USE THIS FORM TO: 1) register to vote 2) change your address 3) request a name change 4) change party affiliation

TO REGISTER TO VOTE AND BE ELIGIBLE TO VOTE YOU MUST: 1) be a United States citizen 2) be at least 17 years old to register but must be 18 years old to vote 3) not be under an order of imprisonment for conviction of a felony 4) not be under a judgment of full interdiction or limited interdiction where your right to vote has been suspended 5) reside in the state and parish in which you seek to register and vote.

INSTRUCTIONS FOR COMPLETING THIS FORM: All information except your signature should be printed clearly in ink, preferably black, or typed. Fill in all boxes that apply to you.

Box 1: Indicate whether you are a citizen of the United States of America. Indicate whether you will be 18 years of age on or before election day.

Box 2: Provide full name. Do not use initials for middle or maiden name.

Box 3: 'Residence Address' means the address where you live and are registering to vote. If you claim a homestead exemption, you must list the address of that residence. Do not use a post office box for your 'Residence Address'. If you use a rural route and box number, draw a map in the space labeled 'Give Location.' Write in the names of the crossroads (streets) nearest to where you live. Draw an X to show where you live. Use a dot to show any schools, churches, stores or landmarks near where you live and write the name of the landmark. Check the box provided if mail is not delivered to your residence address by the post office. Complete 'Mailing Address' only if it is different from the 'Residence Address' or if mail is not delivered to your residence address.

Boxes 5 & 13: You must provide your LA driver's license number or LA special identification card number, if issued. If not issued, you must provide at least the last four digits of your social security number, if issued. The full social security number may be provided on a voluntary basis. If neither a social security number nor a LA driver's license number or LA special identification card number has been issued, and this form is submitted by mail, and you are registering to vote for the first time, in order to avoid additional identification requirements for first time voters, attach either a) a copy of a current and valid photo identification or b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

Boxes 7, 11 & 12: The items 'race/ethnic origin', 'email' and 'phone' are not required but are helpful. Email is protected from disclosure by law.

Box 8: If you do not complete this item, your party affiliation will be listed as 'none', unless you are presently registered with a party affiliation and no change is being made today. If you are not registering with a political party, circle 'none'. The recognized political parties are Democrat, Green, Libertarian, Reform and Republican or you may specify any other party affiliation.

Box 17: If you are using this form to request a change of name, you must print the name to be changed here.

Box 18: Date and sign the card with your signature or mark.

If returned by mail, place in an envelope and mail to the appropriate registrar of voters at the address found on the reverse side of this card. If you have not been issued a social security number or Louisiana driver's license number, you must mail the required documentation with your application. Your application or envelope must be postmarked 30 days prior to the first election in which you seek to vote based on the residence listed on this application.

NOTE: 1. If you decline to register to vote, this fact will remain confidential and will be used only for voter registration purposes. If you register to vote, the office where your application was submitted will remain confidential and will be used only for voter registration purposes. 2. Your social security number will also remain confidential and is intended to be used for voter registration purposes only.

QUESTIONS? Call your Parish Registrar of Voters OR call the Department of State at 1-800-883-2805 or (225) 922-0900.

COMPLETE AND CHECK ALL APPLICABLE BOXES AND CUT HERE BEFORE MAILING.

LOUISIANA VOTER REGISTRATION
APPLICATION

LR-1 & 1M, FORM # 100

OFFICIAL USE ONLY

Wd / Dist _____ Pct _____ Reg Type _____ In/Out _____ REG # _____

1 Are you a citizen of the United States of America? YES ☐ NO ☐ Will you be 18 years of age on or before election day? YES ☐ NO ☐
If you checked 'no' in response to either of these questions, DO NOT COMPLETE THIS FORM.

2 NAME OF APPLICANT (PLEASE PRINT NAME)

LAST

FIRST

FULL MIDDLE OR MAIDEN

GIVE LOCATION

3 RESIDENCE ADDRESS (MUST BE ADDRESS WHERE YOU CLAIM HOMESTEAD EXEMPTION, IF ANY)

HOUSE OR APT. NO. & STREET (IF RURAL, ROUTE & BOX NO.)

CITY OR TOWN

STATE

ZIP

If NO mail delivery to residential
address, check here: ()

MAILING ADDRESS, IF DIFFERENT

4 DATE OF BIRTH

MONTH DAY YEAR

5 * SOCIAL SECURITY #

NO
YES #

(CIRCLE ONE)

6 SEX (CIRCLE ONE)

MALE FEMALE

7 ** RACE / ETHNIC ORIGIN (CIRCLE ONE)

WHITE BLACK ASIAN HISPANIC AMER INDIAN
OTHER: _____

8 PARTY AFFILIATION (CIRCLE ONE)

DEM GRN LBT RFM REP NONE
OTHER (SPECIFY) _____

9 APPLICANT'S PLACE OF BIRTH

CITY OR TOWN

PARISH OR COUNTY

STATE

COUNTRY

10 MOTHER'S MAIDEN NAME

11 **EMAIL

12 **PHONE

HOME ()
DAY ()

13 LA DRIVER'S LICENSE / I.D. # (CIRCLE ONE)

NO
YES #

14 Will you require assistance at the polls? (CIRCLE ONE)

NO YES IF YES, GIVE REASON: _____

15 LAST RESIDENCE ADDRESS

ADDRESS

16 PLACE OF LAST REGISTRATION

PARISH OR COUNTY

STATE

17 FORMER REGISTERED NAME, IF APPLICABLE

AFFIRMATION: I do hereby solemnly swear or affirm that I am a United States citizen, that I am at least 17 years old, that I am not currently under an order of imprisonment for conviction of a felony, that I am not currently under a judgment of full interdiction or limited interdiction where my right to vote has been suspended, that I am a bona fide resident of this state and parish, and that the facts given by me on this application are true to the best of my knowledge and belief. If I have provided false information, I may be subject to a fine of not more than \$2,000 (\$5,000 for subsequent offense) or imprisonment for not more than 2 year (5 years for subsequent offense), or both. Any false statement may constitute perjury.

18 SIGN YOUR NAME IN BOX AT RIGHT.

DATE: _____ / _____ / _____

19 IF YOU ARE UNABLE TO SIGN YOUR NAME, TWO WITNESSES TO YOUR MARK MUST SIGN HERE.

WITNESS SIGNATURE: _____

WITNESS SIGNATURE: _____

* Last 4 digits of the social security number required if no LA driver's license issued; social security number is intended to be used for voter registration purposes only;
full # OPTIONAL ** OPTIONAL

LR-1 & 1M (REV. 06/12) R.S. 18:104; FORM #100